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BEFORE THE U.S. HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS
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Subcommittee Hearing on "HIV Prevention: How Effective is The President's Emergency Plan for AIDS Relief (PEPFAR)?"

WRITTEN STATEMENT

Mr. Chairman, Congressman Kucinich, Congressman Waxman, thank you for this opportunity to join you today to consider the President's Emergency Plan for AIDS Relief or 'PEPFAR' as we've all come to know it. CARE has a long history of implementing HIV and AIDS projects with funding from the United States Government and other governmental and institutional sources. CARE is a nonprofit, nongovernmental humanitarian organization fighting poverty through long-term development projects and emergency relief during natural disasters and conflict. CARE works in 70 countries with more than 12,000 staff worldwide – the vast majority of whom are from the countries in which we work. CARE works in 11 of the 15 PEPFAR focus countries and in four of the five non-focus countries receiving more than $10 million annually from PEPFAR. Our total current PEPFAR budget is $44.5 million. CARE's HIV and AIDS program began with one project in 1987 and by 2005 we had more than 150 projects in 40 countries addressing HIV and AIDS. Our objectives are primarily focused on reducing the number

of new HIV infections, especially among the most vulnerable; mitigating the impact of HIV and AIDS on economic development and community well-being; and increasing access to high quality care and support for affected families. CARE's HIV and AIDS projects are typically community-based, comprehensive, and multi-sectoral.

PEPFAR represents an unprecedented investment and long-term commitment by the U.S. government to the fight against HIV and AIDS. In turn, American funding has allowed CARE and other global health and civil society organizations to design and implement a diverse spectrum of promising approaches to prevention, treatment and care that have positively affected the lives of millions around the world. CARE looks forward to working with Congress and the Global AIDS Coordinator to ensure that this critical investment is sustainable, that we achieve maximum results in the fight against HIV and AIDS, and that the strategies employed in this fight are based on sound, evidence-based public health practices.

In CARE's experience, PEPFAR has contributed energy, resources, and critical momentum to prevention, treatment and care programs in resource-poor countries that have shown tangible results, saved countless lives and provided much needed support in communities with a heavy burden of HIV and AIDS. PEPFAR has also demonstrated crucial leadership, political will and lasting commitment from the United States, all key ingredients in the broader fight to stem the tide of HIV/AIDS. CARE strongly supports the continuation of this valuable program and we are here today to offer our support and our constructive suggestions, drawn from our field experience, to further strengthen the program. Given the critical nature of this initiative, we take seriously the opportunity to help ensure that it can exert the greatest possible impact over the long run.

Today, I would like to raise several issues based on CARE's experience implementing PEPFAR-funded programs, particularly in the prevention area given the focus of today's hearing.

First, there is a crucial need for a more balanced and flexible approach to HIV prevention policy, one that integrates the strengths of A, B, and C programming and enables local decision-making on how best to achieve and maintain that balance.

Second, U.S. prevention efforts need to give far higher priority to activities that reduce gender inequity and the acute vulnerabilities of young women and girls.

Third, PEPFAR prevention programming should intensify its focus on populations at greatest risk, such as sexually active youth, commercial sex workers and injecting drug users (IDUs) among others.

Fourth, PEPFAR should more systematically leverage other development resources and programs that can strengthen the position of women and girls and reduce their vulnerabilities and those of other high risk groups.

Finally, adjustments are needed to strengthen PEPFAR's measurement framework and project timelines.

More Integrative Programming is Needed

The HIV sexual transmission prevention strategy of the U.S. Government centers on the ABC model. The elements of the ABC model are, of course, **A**bstaining from sex, **B**eing faithful to one sexual partner, and correctly and consistently using **C**ondoms. ABC provides individuals with simple, understandable messages on how they can avoid HIV infection. CARE strongly supports PEPFAR and its important work on behalf of

individuals who are or who may become infected with HIV, and in particular, we support and implement each element of the ABC model as appropriate in our global HIV and AIDS prevention work. Much has been written about the 2004 *Lancet* commentary on finding common ground for optimal prevention policy. As co-author of that statement, I firmly believe that "the ABC … approach can play an important role in reducing the prevalence of HIV in a generalized epidemic, as occurred in Uganda. *All three elements of this approach are essential* to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population."[1]

However, in our experience on the ground in resource-poor countries throughout the developing world, OGAC and the country teams responsible for interpreting program guidance have articulated prevention policies and programming with a strong AB preference that leaves too little space or funding for meaningful, integrated HIV and AIDS prevention programming. Our specific concerns include the following:

- *Issuing unclear guidance*. CARE concurs with the finding of the Government Accountability Office (GAO) that OGAC guidance explaining the ABC approach lacks clarity. In our experience with country office teams, OGAC's lack of specific, understandable guidance on its primary prevention approach results in uncertainty of scope and overly conservative interpretations by PEPFAR country teams about what prevention interventions can be included in implementing partners' programs.
- *Defining program content narrowly*. Too often, PEPFAR has emphasized the narrower interpretation of appropriate programming, ignoring meaningful

[1] The time has come for common ground on preventing sexual transmission of HIV. *Lancet* 364, 1913 (2004).

comprehensive programming in favor of a more basic AB message. Our country offices express deep concern that messages about abstinence or faithfulness, de-coupled from the broader reality that most individuals in resource-poor countries face every day, are not effective in influencing high-risk behaviors or promoting safer practices over the long term.

- *Counting AB dollars separately*. For reporting purposes, the program refuses to count funds devoted to comprehensive ABC programming toward the earmark even when the programs contain abstinence or delay-of-debut components, requiring that its AB programs exist in isolation. We know from our work in the field that isolated interventions are rarely successful—accounting for AB resources separately reinforces the 'island effect' of U.S. prevention programming and ignores the synergistic value of more balanced, integrated approaches.
- *Isolating 'high-risk' populations*. By requiring that condom outreach, distribution, and marketing programs be focused only on 'high risk' groups, PEPFAR ignores the sound public-health premise that 'integrated' means integrating A, B, *and* C. In particular, U.S. programming should support truly integrated programming in generalized epidemics (all PEPFAR focus countries in sub-Sahara Africa) where those who are sexually active should all be considered at risk of infection.

CARE's experience, confirmed by the Government Accountability Office's (GAO) recent analysis, is that the ABC approach is interpreted and applied inconsistently across PEPFAR focus countries by USG country teams. In some countries, CARE has

observed that country teams are able to find ways to make A, B and C accessible in a more balanced, integrative way. In other countries, the guidance we receive is more rigid, and fosters the perception that condoms are an undesirable "only if-all-else-fails" option. The variability and uncertainty at the country-team level regarding permissible programming with AB funding is created in Washington but transmitted to CARE and other implementing partners in the field, constraining our ability to design and implement interventions that best respond to local circumstances.

In our conversations with CARE field staff in preparation for this hearing, one experience in particular stands out. In a CARE project in one of the PEPFAR focus countries with a generalized epidemic, our country office approached USAID with an innovative proposal to work with sexually-active youth engaging in transactional sex for money. Our proposal would have provided treatment for sexually-transmitted diseases and training for alternative livelihoods to reduce the economic dependence of these desperately poor children. Unfortunately, OGAC turned down our request for AB funding but suggested country office staff resubmit the proposal for OVC care and support funding to pursue the same objectives. Ultimately, though after considerable delay, this innovative proposal was accepted and funded with OVC funds. But think about the implications here. Why does programming designed to treat STDs and draw children out of transactional sex work, a high-risk activity for HIV infection, not qualify for U.S. prevention funding? The answer, regrettably, is simply because U.S. policy has compartmentalized prevention funding into arbitrary categories, "AB" and "Other Prevention", with simple deliverables that must be 'rolled up' to the national (and global)

level every year. The result is unfortunate: a rigid interpretation results in significant delay while bold and innovative programming becomes harder to fit and harder to fund.

We recognize that this is as a result of the underlying statutory requirement included by Congress in the Global AIDS Act that requires U.S. prevention programming to devote at least one-third of its funding to abstinence-until-marriage programming. Unfortunately for implementing organizations like CARE, the statutory restriction constrains OGAC's ability to support the design and implementation of more comprehensive and flexible programming. We are encouraged by recent legislative initiatives in both the House and the Senate to modify or eliminate this restrictive requirement. Though A and B programming are both important in certain settings for specific populations, as we've said before, an integrated approach that balances all three elements and addresses the complicated realities of individuals living in resource-poor countries is strongly preferable to an arbitrary formula with no basis in public health evidence or practice. CARE urges Congress to consider modifying or repealing the AB set-aside to substantially increase the ability of PEPFAR country teams and implementing partners to respond to local circumstances.

Fully Address Gender as a Determinant of Vulnerability

In sub-Saharan Africa, women represent 60% of those infected with HIV and 75% of those infected between the ages of 15 and 24. Young women age 15-24 in South Africa, Zambia and Zimbabwe are three to six times more likely to be infected than are young men. One in four women in South Africa is HIV-infected by the age of 22.[2] In our experience, women and girls are disproportionately infected by HIV because they are

[2] Quinn T, Overbaugh J. HIV/AIDS in Women: An Expanding Epidemic. *Science* **308**, 1582 (2005).

less able to negotiate sexual relations, they are more prone to sexual violence, they are often married at an early age to older men and they are more susceptible to pressure to engage in transactional and inter-generational sex.

Women and girls in these countries are only meaningfully engaged by the ABC model when they are free to choose to abstain from sex, or to choose to enter or to remain in a relationship where their own faithfulness is reciprocated and thus truly protective, or to avail themselves of condoms where they can negotiate correct and consistent use. In those instances, ABC as a preventive strategy—including AB for appropriate target populations—is an effective intervention. But wherever women cannot control the sexual encounters they engage in, either for reasons of rape or abuse, gender disempowerment, economic dependency, or cultural practices, ABC in its current formulation is significantly more problematic. Worldwide, thousands of women and girls are infected with HIV daily in settings where saying no to sex or insisting on condom use is not an option because of cultural factors, lack of financial independence, and even the threat of violence."[3] The following predicament of a young African woman, as conveyed to a member of CARE's field staff, is all too common: "I am a widow and have no family around me, except my small children. People in the community know I am poor and alone and thus more vulnerable. As I have no one to protect me and no money, I am often forced to provide sexual favors to officials, military and even my brother-in-law."

In CARE's experience, many women and girls are unable to choose to remain abstinent due to the high prevalence of rape and gender-based violence (GBV) in far too many countries. In Burundi, CARE found that 15 percent of men admitted to raping someone at least once in their lives. It is clear that we must do more to change men's

[3] Fauci, A. Twenty-Five Years of HIV/AIDS. *Science* 313, 409 (2006).

behavior. We must find ways to engage men more fully so that they are equal partners in the fight against HIV and AIDS. Moreover, rape and GBV all too often go hand-in-hand with conflict and instability. For example, in the Great Lakes region of Central Africa, a woman told CARE staff, "I was raped two years ago by a man in uniform . . . Fifteen hours after he committed this ignoble act he told me, 'I got AIDS by paying for sex. You are lucky; I gave it to you for free.'" Darfur and eastern Congo are two current, terrible examples where unthinkable numbers of women and girls have been raped or coerced into sex. In countries where the costs of going to school are high, too many young girls participate in transactional sex, often with older men and sometimes with their own school teachers, in order to be able to cover the costs of school or simply to contribute to meeting their family's basic needs. One African woman told CARE, "I was one of the few lucky to go to school. However, my teacher kept harassing me when I arrived. I asked a friend about this and she said, 'If you want to pass the exam, you have to agree to his sexual demands.'" Women may also enter into such relations so that they and their families can survive. CARE and others' assessments in Rwanda point to an alarmingly high rate of young women and girls who are or who have been sexually abused or engaged in "survival sex".

Worldwide, 80 percent of women newly infected with HIV are practicing monogamy within a marriage or long-term relationship. Sadly, their husbands and partners are not. Under AB programming, CARE country offices have encouraged couples to be faithful to each other despite the reality, in many cases, that many couples either do not know each other's status or at least one partner is or may be infected and discordant. Certainly for women who faithfully respect the sanctity of their marital bonds

but who are unknowingly exposed to the HIV virus by a discordant husband, PEPFAR's current approach is of little or no value at reducing the likelihood that they will contract HIV and AIDS.

CARE's experience shows that no single approach can effectively prevent HIV infection. For instance, married women in sub-Saharan Africa have one of the highest HIV prevalence rates. Promoting abstinence or fidelity will not protect them from HIV, since it is often their husbands who infect them. If we're emphasizing faithfulness in this context, it has to focus as much or more on men than women, and it has to recognize that relationships of economic or cultural dependency where women do not have the power to refuse unprotected sex *are* the problem, not the presence or absence of faithfulness per se. OGAC has rightfully acknowledged that working with men in peer groups is essential to transforming underlying gender norms that endanger women. CARE has found that such interventions are critically important and should be encouraged. As one African man recounted to a member of CARE's field staff, "My wife was raped and I threw her out of the house. A neighbor helped her and tried to talk to me, but I refused to listen to that woman. Later, the men from the association came to talk to me. They explained what had happened and that it was not my wife's fault. They said she was neither seropositive nor pregnant. They encouraged me to take her back into the home." Men, alongside women, must be leading the fight against sexual violence and PEPFAR can do even more to help make that happen.

Too often in our conversations with field staff in preparing for this hearing, we heard that despite the critical importance of gender as a determinant of vulnerability for people at risk of contracting HIV and AIDS, gender inequity still is not a sufficient focus

of PEPFAR nor an area that PEPFAR is especially effective at addressing. Too many women and girls are becoming infected with HIV and dying from AIDS. We have to do better.

Engage Vulnerable Populations

The risk of infection is significantly higher among certain vulnerable populations, including sex workers, injecting drug users (IDUs), sexually active adolescents and children, prisoners, men who have sex with men (MSMs) and other individuals whose activities or practices put them at higher risk of contracting or spreading the HIV virus. In many countries, CARE's HIV and AIDS and reproductive health programs reach sex workers and others engaged in sex in exchange for food, money or other resources through interventions designed to reduce the risk of infection or activities to expand livelihood opportunities.

CARE's vision places human dignity at the very center of our work. We seek to protect and advance the dignity of all people, especially those who are living in poverty and at the margins of broader society. CARE is committed to addressing the underlying causes of poverty and vulnerability, and helping poor communities become empowered to seek the fulfillment of their rights. In the countries in which CARE works, many people are marginalized and vulnerable for many different reasons, including gender, poverty, age, caste, religion, occupation and ethnicity. Although individuals in resource-poor countries are entitled to the same basic human rights as people in more privileged positions, they are often not able to avail themselves of those rights. Their access to health care, education, housing and employment is limited, their personal security is

constantly at risk, and they are prevented from realizing their full potential as human beings.

CARE seeks to advance our vision by working alongside marginalized and vulnerable people, helping them to claim their rights and fulfill their responsibilities. We also help to hold people and institutions with duties to protect and uphold those rights accountable. CARE works with vulnerable and marginalized groups in a wide variety of settings: examples include low-caste and tribal groups in India, child soldiers in the Democratic Republic of Congo, girls subjected to female genital cutting in Ethiopia, indigenous populations in Bolivia, and people subjected to gender-based violence and exploitation throughout the world. In each case, CARE stands in solidarity with such groups to enhance their most basic human rights and positions in society.

In our HIV and AIDS and reproductive health programs, CARE works with many groups that are vulnerable, including sex workers, injecting drug users, men who have sex with men, and women and girls engaged in transactional sex among others. Because of gender disparities, cultural norms and socio-economic pressures, these groups exist on the margins of society. They are especially vulnerable to violence, unplanned pregnancy and sexually transmitted infections, including HIV. If these groups are not effectively reached by HIV and AIDS programming, they can be disproportionately infected by HIV and become significant drivers of the epidemic.

CARE works with vulnerable groups as a service provider, facilitator, and partner. Our evidence base demonstrates that addressing vulnerability and reducing stigma are essential elements of effective strategies to fight HIV and AIDS, and must underpin successful prevention, treatment and care efforts. Medically-focused interventions alone

directed toward these groups are insufficient to address the HIV and AIDS pandemic. Vulnerable groups must be willing and able to access these services, and use the information they receive. This cannot happen as long as these groups are pushed "underground" or shunned by society.

CARE's programs seek to facilitate the empowerment of individuals in these groups, so that they can secure their basic needs and human rights, and expand their range of choices and opportunities. We understand that vulnerability stems from social, economic and cultural factors, and our activities seek to address these underlying factors, for example, by providing alternative vocational training, counseling and legal referrals, building leadership and negotiation skills, and creating networks of peer educators for condom distribution, management of clinics and prevention communication.

Currently, PEPFAR is funding and supporting too little vulnerable-populations prevention work. In one especially telling example, a CARE field staff member in a high-prevalence PEPFAR focus country told us that the USG country team had specifically suggested that they should seek other – non-PEPFAR – funding for addressing vulnerable populations. To improve its effectiveness at reaching these important but marginalized populations, PEPFAR must significantly increase its investments in well-established interventions that reduce stigma around HIV and AIDS and discrimination and abuse of vulnerable populations; encourage safer sex among sex and transport workers; harm reduction strategies and effective treatment for IDUs and other vulnerable populations; structural interventions to positively affect the social, political, or cultural environment in which infection and transmission occur; and more comprehensive, engaged programming directed at sexually active youth. In CARE's

experience, not enough PEPFAR funding for 'other prevention' is supporting work with vulnerable populations, nor is PEPFAR funding the more creative, highly responsive interventions that can meaningfully engage these populations and reduce their likelihood of contracting or transmitting the HIV virus. These populations are at significant risk; we must do a better job.[4]

In this regard, we are also concerned about the U.S. prostitution pledge requirement. To effectively prevent HIV and AIDS, CARE works with vulnerable groups who exist on the margins of society. Sex workers represent an especially high-risk population that we must reach in order to strengthen prevention efforts worldwide. Because they are often shunned by society and pushed "underground," sex workers are not able to receive the information and health services necessary to protect them from HIV and AIDS and other sexually transmitted diseases. Even when they have access to information and services, sex workers are often not able to protect themselves effectively because they don't have the power to negotiate safe sex. CARE works to help vulnerable individuals, including sex workers, to better protect themselves against HIV and to cultivate a broader range of economic options for themselves and their families.

CARE believes the U.S. prostitution pledge requirement is counterproductive in the fight against HIV and AIDS and supports the legal efforts currently underway to overturn the requirement. In our view, the pledge requirement threatens to drive a wedge between implementing organizations like CARE and the vulnerable populations whose trust and respect we must preserve in order to combat HIV and AIDS effectively. CARE is also concerned that the application of the current pledge requirement to non-U.S. non-

[4] *See e.g.*, Report on the Global AIDS Epidemic. Geneva: UNAIDS; 2006: 106 ("In China, it is estimated that sex workers and their clients account for just less than 20% of the total number of people living with HIV" (Ministry of Health, People's Republic of China/UNAIDS, 2005)).

governmental organizations adversely affects their work on behalf of poor, marginalized people. We stand with our partners and urge Congress to consider repealing this provision in its entirety as it looks for new opportunities to strengthen PEPFAR and to increase the effectiveness of U.S. HIV prevention policy.

Comprehensive Programming is Needed

As we look toward PEPFAR reauthorization in 2007-08, it is important to begin to articulate the components of a truly effective U.S. prevention policy. From CARE's perspective, we have to integrate A, B, and C wherever appropriate and in whatever configuration is most likely to increase the effectiveness of meaningful prevention over the long term, but we must go beyond the simple ABC formula to recognize that access to education for young girls, economic and gender empowerment, public health infrastructure, protection from sexual violence, and food security and livelihood options for desperately poor people are the ultimate foundation on which an effective prevention strategy in resource-poor countries must be built.

PEPFAR could be considerably stronger in addressing vulnerability if it took a broader health and development approach to combating HIV and AIDS. PEPFAR's work is often too clinical, disease-specific and narrowly medical in focus. Despite its medical and public health context, HIV and AIDS is not a health issue alone. The underlying causes of the spread of HIV and AIDS reflect a combination of many non-health factors such as poverty, gender inequality, stigma and social and cultural norms. As one African woman told CARE staff, "I received more than once, nightly visits from the local chief harassing me and I had to give in so that I could feed my children. It is

difficult to escape what is linked to survival." Additionally, the impact of HIV and AIDS on families, communities, and societies goes well beyond health alone. Congress should consider expanding U.S. HIV and AIDS programming beyond medically-focused prevention, treatment and care to more effectively leverage its HIV and AIDS funding and other foreign assistance resources.

Appropriate, carefully targeted food aid, community gardening to enhance food and nutritional security, inheritance and property rights protection, and small scale economic development through microfinance and microenterprise are program areas that PEPFAR should actively embrace to better address food and nutritional insecurity and to relieve chronic economic pressures that increase vulnerability to HIV infection in poor countries. In one troubling example confirmed by several CARE country offices, CARE staff raised the issue of inadequate nutrition for people living with HIV and AIDS on ARV therapy. Despite the critical need, CARE staff have not been able to secure resources to address the problem because, they were told by USAID, "PEPFAR does not have the mandate." All too often, there are no other agencies, even within the USG, stepping up to fill PEPFAR's gaps. A colleague from another of our PEPFAR-supported country offices reported that, recently, the USAID Health Team in country passed her to their colleagues in the Economic Growth Team (down the hall) to seek food and economic strengthening resources for the most HIV and AIDS-affected families. Shortly thereafter, CARE was informed by the Economic Growth Team that such resources were not available and that what was needed was more money for food and economic security interventions from PEPFAR! The lack of communication and agreement on a coordinated approach to address such a major priority was hard to swallow, and our

impression is that this was not an isolated case – USG coordination and complementarity appear to be lacking in all PEPFAR countries.

Several CARE offices have developed innovative, multi-sectoral interventions with communities affected by HIV and AIDS but only after struggling to mobilize alternative, non-PEPFAR resources. While we recognize that PEPFAR resources must focus on HIV/AIDS and cannot bear the burden of engaging the totality of U.S. development assistance, encouraging examples of focused multisectoral programs are emerging across the developing world and should be carefully examined – and more robustly supported – by PEPFAR administrators and USG country teams. Better coordination with other USG development and food and nutrition funding sources must be operationalized on the ground in order to ensure an effective and sufficiently resourced multi-sectoral approach.

Another serious concern of CARE country offices is focused on programs designed to prevent mother-to-child transmission of HIV (PMTCT). Many PEPFAR PMTCT projects are simply too narrow and fail to incorporate the full range of services that women in resource-poor countries need and want. First, PMTCT is significantly strengthened by ensuring that women can prevent unplanned pregnancies. In our experience, many PMTCT services are utilized by women who would have preferred not to become pregnant. An integrative PMTCT regimen should ensure that HIV-positive women who prefer not to become pregnant are able to access the full range of family planning and reproductive health services. Secondly, for HIV-positive women seeking to have children, PMTCT programs should focus on both appropriate anti-retroviral therapy *and* child survival. In too many instances, CARE staff have witnessed tragic outcomes

when mothers who are successful at preventing antenatal HIV transmission lose their infants to diarrheal illnesses that are easily preventable through access to safe water or low-cost interventions like oral rehydration therapy (ORT). On other occasions, young mothers are given information on the risk of passing HIV to infants through breastfeeding, but do not receive assistance to allow them to access infant formula.

Several CARE country offices have raised these concerns with USG country teams and asked for help at finding additional funding for a more comprehensive PMTCT approach. Unfortunately, on most occasions they were told that integrated PMTCT could not be supported. All U.S. PMTCT programs should incorporate reproductive health and family planning services for women who prefer to avoid pregnancy and provide integrated programming to protect newborn infants from HIV and other readily preventable illnesses. This is another area where better coordination with other USG foreign assistance funding sources, including child survival and reproductive health funding, could strengthen PMTCT programming.

Although, there is general support for the so-called wraparound approach requiring strong and regular "coordinat[ion] with and leverag[ing of] resources from other agencies and sectors, such as nutrition and education, to promote comprehensive and effective responses,"[5] PEPFAR in its current configuration has largely failed to adequately address the broader health and development causes and consequences of HIV and AIDS. Beyond OVC care and support programs, relatively few PEPFAR-supported programs address economic and social issues related to HIV and AIDS. These programs are often neglected, apparently in the hope that other agencies – whether USG or

[5] "Action Today, A Foundation for Tomorrow: The President's Emergency Plan for AIDS Relief: Second Annual Report to Congress." Page 13. http://www.state.gov/documents/organization/60598.pdf

otherwise – will 'wrap around' PEPFAR's mainly clinically-focused work to achieve a multi-sectoral, holistic response. To work effectively, this wrap-around approach entails real, ongoing, on-the-ground coordination, planning, and resource pooling with other agencies. The reality remains far removed from the ideal and leaves the goal of comprehensive programming largely unfulfilled.

Operational Challenges

CARE appreciates PEPFAR's commitment to accountability and we agree completely that it is essential to systematically monitor and meaningfully assess program outcomes to ensure the maximum return on the U.S. and host governments' investments in the fight against HIV and AIDS. That said, after conducting many conversations with CARE and partner staff implementing PEPFAR interventions around the world, the manner in which PEPFAR's results measurement and evaluation framework has been implemented requires attention by policy makers. Above all, PEPFAR's ambitious 2-7-10 targets are driving a single-minded pursuit of highly specific results, producing an excessive focus on quantitative process outputs without sufficient attention to program sustainability, impact evaluation and continuous learning.

Sustainability in particular can be jeopardized when narrowly-focused U.S. programming emphasizes meeting numerical targets over engaging the underlying causes and consequences of HIV and AIDS. In one especially hard-hit PEPFAR focus country, for example, CARE's model OVC care and support program was criticized as too expensive on a cost-per-OVC basis. To meet OGAC targets for numbers of orphans and vulnerable children "reached," CARE was pushed to scale back key investments in

support of local ownership and community capacity building. According to field staff, the pressure was enormous to reduce or eliminate planned investments in community support networks and promotion of food and income security. In CARE's long experience in community development, we have learned that such interventions are key to ensuring program sustainability and to improving, in the long run, the quality-of-life and well-being of vulnerable children. As this and other CARE experiences illustrate, Congress and the Administration must find a more productive balance that ensures sustainability and durable change from U.S. investments in the fight against HIV and AIDS. Effective measures have to assess the degree to which PEPFAR programming encourages economic, social and cultural transformation that can take root locally and be sustained over the long term.

In addition, in assessing PEPFAR program evaluation and learning, CARE urges greater, more systematic attention to the crucial question of impact measurement. Are the individuals who receive information or education about abstinence, faithfulness, or condoms actually modifying behaviors to reduce risk, and do we know the ultimate impact in averted infections? It is certainly challenging to measure behavioral outcomes successfully, but crucial investments in impact evaluation and continuous learning should not be sacrificed to PEPFAR's "full speed ahead" emergency mindset. In the long run, we have to be sure that we are doing the best job possible with PEPFAR resources. Or as one of my colleagues with extensive, on-the-ground PEPFAR implementation experience wondered recently, "Are we building a bunch of straw houses here?"

Finally, in addition to its excessive focus on numerical targets, PEPFAR programming tends to involve short contracting periods. The short-term nature of

PEPFAR programming makes it difficult to address one of the key goals of the U.S. Five-Year Global HIV/AIDS Strategy to "develop sustainable HIV and AIDS health care networks" and to build local capacity for the long term.[6] From CARE's long and extensive experience in building local capacities to address HIV and AIDS, we have learned that it takes time to build trust and truly enable meaningful, effective, and sustainable community-based interventions. Small community-based or faith-based organizations operating in developing countries generally do not have the ability to absorb large amounts of funding, conduct effective programming, and measure results on six-month or one-year contracts. They need to be accompanied and supported over a multi-year period to enable analysis of HIV and AIDS' causes and consequences and engender community solidarity and action planning to respond. Enabling women's participation and creating a climate in which the potential of women's leadership can bear fruit is an especially lengthy effort, since it must go hand in hand with a profound process of social change in order to be truly sustainable. CARE shares OGAC's commitment to devolving more HIV prevention, care and treatment service delivery to local organizations and local government entities. But let us be clear that longer-term investments are needed to ensure that local organizations and government entities will be capable of continuing to provide – responsibly and effectively – these crucial services in the future.

[6] "The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy." Page 8. http://www.state.gov/documents/organization/29831.pdf

Conclusion

Let me close by saying that we welcome the opportunity to work with this committee and with our partners at the Office of the Global AIDS Coordinator to strengthen U.S. prevention practices and to reduce, wherever possible, the likelihood that any individual worldwide will contract HIV and AIDS.

I look forward to answering your questions Mr. Chairman, Congressman Kucinich, Congressman Waxman. Thank you